

Conscience absolutism via legislative amendment

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Peter West-Oram and Jordanna A. A. Nunes

Abstract

On the 30th June 2021, Ohio state Governor, Mike DeWine, signed a Bill which would enact the state's budget for the next two years. In addition to its core funding imperatives, the Bill also contained an amendment significantly expanding entitlements of health care providers to conscientiously object to professional duties to provide controversial health care services. This amendment has been heavily criticised as providing the means to allow health care providers to discriminate against a wide range of persons by denying them access to often contested services such as abortion and contraception.

In this paper we examine the implications of this amendment and situate it in relation to other legislative actions intended to guarantee absolute rights to conscientious objection. In doing so, we argue that the entitlements extended to health care providers by these Bills are overly broad and ignore their potential to allow significant harm to be caused to clients. We then argue that if health care providers should have rights to conscientiously object (a question we do not try an answer here), then any legislation intended to protect such rights should be limited, specific, and parsimonious. Where it is not, the ideological liberty of HCPs treads dangerously on the physical freedom of their clients.

Introduction

On the 30th June 2021, Ohio state Governor, Mike DeWine, signed the Bill which would enact the state's budget for the next two years.⁽¹⁾ In addition to its core funding imperatives, the Bill also contained an amendment significantly expanding entitlements of health care providers (HCPs) to conscientiously object to professional duties to provide controversial health care services.⁽¹⁾ This amendment has been heavily criticised by LGBT organisations, which have argued that it provides significant scope for health care providers to refuse service to members of the LGBT community.⁽²⁾ Simultaneously, the amendment would also allow significant freedom to HCPs to refuse to provide often contested services such as abortion and contraception.

The Ohio Amendment has not emerged from a vacuum. Indeed, far from being a radical departure from the discourse surrounding conscientious objection, it is merely the latest in a series of legislative and litigative manoeuvres which erode entitlements to basic health care services by pushing for an absolutist understanding of HCP's individual freedom and rights to conscientious objection.⁽³⁾ Our goal in this paper is to highlight the implications of the Ohio Amendment's extensions of the right to conscientious objection, and argue that its conscience absolutism undermines important principles of justice in health care provision.

To achieve this goal, we first situate the Ohio Amendment in its context of other Bills and legal proceedings aimed at extending the right to conscientious objection. Second, we examine the arguments given for granting “conscience based exemptions” (CBEs)(4) to health care providers. Third, we note that the exemptions granted in the USA specifically may reasonably be seen as analogous to a deliberate strategy identified by the Guttmacher Institute, to limit access to contraception and abortion.(5) Fourth, we show how the CBEs granted by the Ohio Amendment depart from, and undermine, what Daniel Brock has called the “conventional compromise” in conscientious objection.(6) Finally, we argue that in so doing, that the concessions granted by these Bills exceed what can be reasonably justified by the (potentially legitimate) concern for the personal liberty of health care providers.

The Ohio Amendment in Context

Conscience protection laws are not a recent phenomenon in the jurisdictions with which we are concerned in this paper, having emerged alongside, and in response to laws permitting abortion in the United States(7) and United Kingdom (indeed in the UK, the conditions for CBEs to the provision of abortion is written into the 1967 Abortion Act).(8) However, in recent years, the long running debate surrounding conscientious objection in health care has become increasingly heated.(9–11) This is partly because of the increasing number of cases in which requests for CBEs are made, and partly because of the way in which appeals to freedom of conscience are used in increasingly expansive ways that limit the rights of clients to basic health care services.¹ Equally, the enactment of the Obama Administration’s *Patient Protection and Affordable Care Act* (PPACA) prompted a number of legal challenges to certain provisions of the Act on grounds that they obliged employers and insurers to

¹ Following West-Oram and Buyx, we use the term “client” to refer to those accessing health care services in conscientious objection scenarios, since conscience claims can also be made by pharmacists and other providers who do not have “patients”. (10)

provide insurance coverage for services which some people may believe are immoral.(9–12)

The scope of these various legislative and litigative expansions of the right to conscientiously object in the health care context varies. The British Abortion Act for example offers relatively limited concessions to objectors, while more recent legislation in Mississippi provides extremely broad scope to the range of health care services from which objecting providers may excuse themselves.(13) Indeed, the both the Mississippi Act and Ohio Amendment expand the range of agents that may excuse themselves from participating in the provision of such services in this way, to include non-clinical health care staff, as well as health insurance providers and employers.(1,13) This expansion of conscience rights to insurers and employers was also expanded at the American Federal level by the Supreme Court of the United States' (SCOTUS) ruling in *Burwell vs. Hobby Lobby et al.* which found in favour of a group of religious employers who wished to opt out of paying for insurance coverage for certain contraceptives which were mandated by the PPACA.(10,14) Further extensions and expansions at the State and Federal level were made by later lawsuits,(11,12,15) while Texas and Arkansas each enacted legislation further entrenching HCP rights to conscientious objection.(15,16) Importantly, this expansion of the right to conscientious objection is not a uniquely American phenomenon – in the United Kingdom, a Bill aimed at a similar expansion of the rights of health care workers to conscientiously object to participating in the provision of contested services is currently under review in the House of Lords.(17)

Collectively, these legislative efforts serve to empower health care providers in their various legislations and extend their rights to opt out of otherwise applicable professional duties. In some cases, such as the bill proposed in the UK, this would “merely” extend the reach of existing professional entitlements (allowing physicians to opt out of more things), while in others, such as the Mississippi Bill, and Ohio Amendment, new categories of agent are granted privileges that they have not previously enjoyed, and/or limited what is

required of providers for a CBE to be granted. While enacted in different jurisdictions, these individual pieces of legislation and litigation can be seen as part of an increasing trend to prioritise a specific type of individual liberty of HCPs (to complete ideological freedom) regardless of the consequences for other persons. As we argue in the following section, the pursuit of this goal ignores connection between HCP exercise of freedom, and denial of freedom of others.

Ideological Freedom in Relation to Other Rights

The right to conscientiously object is argued to be a necessary derivative of the right to freedom of conscience which ‘defines the limits of political obligation’.(18) Guaranteeing a right to conscientious objection is therefore argued to be necessary in order to avoid discriminating against those with minority moral perspectives, and enable them to participate fully in society without having to perform actions which they believe to be immoral, such as providing abortions, or joining the military.(10) To require such compliance is argued to be harmful to objectors because it does not respect their autonomy, and restricts their individual freedom to make private choices.(19)

These defences of rights to conscientious objection are framed in terms of the harm that would be inflicted on objectors by requiring them to perform actions they hold to be immoral. The focus is therefore entirely on the identity and beliefs of the objecting provider. They and the consequences of their actions are therefore taken to be independent and causally isolated from other agents. The consequences for the client, and indeed their demographic identity, is thus claimed to be irrelevant to the objecting provider and those advocating for the extension of their professional freedoms. It is therefore argued not to be a matter of denying access to or discriminating against *clients*, but merely of avoiding harm to the provider by requiring them to participate in the provision of a *service* to which they assert a moral objection.

Objecting to a Service versus Discriminating Against a Person

However, even if this “service not person” claim is sincere, it does not provide adequate justification for the broad rights to conscientious objection guaranteed by the legislation noted above. Further, the exclusive focus of conscience advocates on the wellbeing of providers leads to significantly harmful consequences for the clients of objecting HCPs. For example, as noted by the Human Rights Campaign, the provisions of the Arkansas Act are so broad they would allow harmful denials of care to members of the LGBTQ community, on the grounds that the care in question was contrary to the beliefs of an HCP.(20) Such provisions also make it harder to prove that a denial of service was the result of unlawful discrimination against a member of a protected group, or because of the legal exercise of a right to conscientious objection. To illustrate with the conventional case, it is possible for a physician to refuse to provide an abortion to their patient under the legislation noted above; physician A may refuse to provide an abortion to anyone, because they believe that abortion is immoral. In contrast, physician B may refuse abortion to patients, not because they oppose abortion *per se*, but because they believe that women are not entitled to the same bodily integrity or reproductive autonomy rights as men (though as we argue below, these positions are closely entwined). Where physician A merely objects to providing a service they believe is immoral, physician B is motivated by discriminatory animus against women. Unless physician B reveals their motivation, it would be impossible for any of their clients to prove that they had been discriminated against, and that their physician had acted in a manner not covered by their right to conscientious objection. Thus, the laws provide tremendous scope for covert discrimination under the guise of legal conscientious objections.

There is also good reason to question the sincerity and validity of the “service not person” claim noted above.(5) While *some* weight must be given to the claims that discrimination and/or denials of service are not the goal of the noted laws, their consequences alone give reason to be sceptical about the validity of this argument. To illustrate, in the United States, there is a deliberate and concerted effort to limit access to abortion and contraception via so called “TRAP Laws” (Targeted Regulation of Abortion Providers).(5,21)

Such laws are typically framed by their advocates as ways to protect women and deliver higher quality care. However, they have been widely criticised as frequently imposing unnecessary restrictions which limit access to care without improving it, and in some cases actively making it worse.(21) Analogously, as discussed above, conscience laws offer significant protection to HCPs, but offer little or no consideration of the impact on their clients, with similarly predictable consequences.(7,10,22) There is thus a similar disconnect between the justifications offered for TRAP laws and extensions of the right to conscientious objection, and their anticipated and realised outcomes. Where TRAP laws are defended on grounds of protecting women, conscience exemptions are promoted as a means to protect the moral integrity of HCPs. Both have entirely predictable, harmful consequences for similar demographics, whose access to care is subject to the ideological commitments of legislators and HCPs precisely because in both cases those consequences are not considered. Thus, even if the aim of TRAP laws and CBEs is not discriminatory, they often cause significant discriminatory harm.

Avoiding Discrimination Through Compromise?

Given the potential for harm to be caused to clients by the denials of service of objecting HCPs, legislation granting rights to conscientious objection often includes requirements intended to ensure that clients retain access to contested services. For example, CBEs are typically not permitted in emergency situations, and objecting providers are often required to refer clients to alternative sources of provision.(8) Collectively, these provisions have been loosely categorised as the “conventional compromise”, intended to ensure an approximation of a satisfactory outcome for all parties.(6) Providers are not (usually) obliged to participate in the provision of care to which they assert a moral objection, thus maintaining significant professional and personal freedom and avoiding the harm of participation in actions they believe to be immoral, while clients retain access to contested services. This compromise remains controversial however, with some conscience advocates arguing that referral merely moves the objecting provider one additional step away from the

contested service being provided, meaning that they still retain (marginally more distant) causal responsibility for its delivery. (23,24)

The Ohio Amendment leans away from the conventional compromise, and while it does contain language which suggests that referral to an alternative source of medical provision may be appropriate, it is entirely at the discretion of the medical practitioner.⁽¹⁾ Indeed, the “duty” to refer is also subject to the right to conscientiously object under the Ohio Amendment, and there is no obligation to ensure that another HCP is willing or available to provide the contested service.⁽¹⁾ Thus, there is no conventional compromise in Ohio. As noted, there are reasons to question the legitimacy of the conventional compromise, given that it does not remove objectors from the causal chain leading to the provision of contested services, and thus may be suggested to not actually reflect a genuine compromise.⁽²⁵⁾ However, in its absence, access to contested services becomes tenuous at best, since providers can conscientiously object in most contexts, and have no responsibility to ensure that clients they reject are able to find care elsewhere. Ohio therefore presents (another) case study demonstrating the consequences of unrestricted and uncompromising rights to conscientious objection. If HCPs may refuse any health service without an obligation to refer, their clients will almost certainly face significantly reduced access to care. The breadth of the provisions in the Ohio Amendment are so extensive that they present an alarming foreshadowing of the potential for “anarchy” in the health care system,⁽²²⁾ whereby virtually anyone can assert an objection to virtually any care. The uncertainty of access to care created by such an outcome is innately harmful to clients, because it means that in contexts of significant vulnerability and medical need they will not know whether they will be able to receive potentially urgent care, or whether their claims will be rejected.

In addition, while the Ohio Amendment does require that providers declare any objections publicly in advance, the breadth of the freedoms to conscientiously object, and the indemnity from discrimination for so doing that the amendment guarantees, means that the organisation of the provision of care, particularly

where that care is subject to controversy, will be extremely challenging for administrators of health care systems. Thus, the compensatory burdens generated by the extremely broad rights to conscientious objection contained within the various pieces of legislation noted above, falls on the colleagues of objectors, as well as their clients.(22) Importantly, this burden is imposed, and is harmful and unjust, regardless of whether this institutional and structural anarchy is caused by discriminatory animus, or the exercise of rights to freedom of conscience.

Conscience Absolutism Vs. Compromised Conscience

The freedom to live according to one's personal moral code and avoid being forced to perform actions one holds to be immoral is integral to our entitlement to be acknowledged as autonomous moral agents. Nevertheless, this freedom is, and must be, constrained by the effect of its exercise on other people.(10) Conscience is important, but undue deference to it, and legislating with excessive breadth and insufficient regard for the distribution of the compensatory burdens required to facilitate CBEs allows for the imposition of harmful consequences upon people who are already the target of discrimination and persecution. The Ohio amendment further undermines our legislative understanding of the appropriate responsibilities of HCPs by interpreting CBEs as purely a matter for the private interests of HCPs, independently of their impact on clients, colleagues, and society more broadly. While it is argued that the intention is not discriminatory, and that the focus of CBEs in the Bill, and its analogues, is on avoiding contested services, rather than disrespected persons, the effect is the same – the state license of almost absolute, unconstrained freedom to HCPs at the cost of the welfare of already marginalised people, to say nothing of the administrative and professional burdens imposed on non-objecting HCPs who will incur additional duties to compensate for the objections of their colleagues. *If* it is legitimate to permit CBEs in the health care context, and we make no claim to either answer here, then any legislation intended to protect the ideological freedom of HCPs should

be limited, specific, and parsimonious. Where it is not, the ideological liberty of HCPs treads dangerously on the physical freedom of their clients.

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